TRANSMITTAL FOR MEDICAID LEVEL OF CARE ELIGIBILITY

State Form 46018 (R4 / 8-05) / HCBS 0007

☐ Aged or Disabled ☐ Autism ☐ MFC ☐ TBI ☐ AL ☐ AFC ☐ DD ☐ Sup Srv ☐ ICF / MR

Name	Medicaid number

Address (*number and street*)

City, state, ZIP code

Name of guardian

Address (*number and street*)

City, state, ZIP code

Name of case manager requesting L.O.C.	☐ BDDS ☐ AAA ☐ Waiver Only

Name of agency

Address (*number and street*)

City, state, ZIP code	Telephone number ( )

Purpose of Level of Care Determination

☐ Initial ☐ Annual Redetermination ☐ Other *(specify)* _____

Waiver Displacement Status

☐ Diversion ☐ Deinstitutionalization From: ☐ Nursing Facility ☐ ICF / MR

Name of facility

Address of facility *(number and street, city, state and ZIP code)*

Date *(month, day, year)*

The diagnostic information is a current and valid reflection of the individual.

Signature of reviewer

NURSING FACILITY RESIDENTS ONLY

OBRA 1987 Residential Alternative Offered:

☐ Not Applicable

☐ Residential Choice *(attach form)*

STATE OFFICE OF MEDICAID POLICY AND PLANNING USE ONLY

This application cannot be finalized due to: ☐ Missing Forms ☐ Missing Data ☐ Clarification needed

Comments

☐ **Approved for Level of Care**

☐ Hospital ☐ ICF / MR ☐ NF / I ☐ NF / S ☐ NF / TBI
☐ NF / AL ☐ NF / AFC

☐ **Disapproved for Level of Care - SEE ATTACHMENT**

☐ Hospital ☐ ICF / MR ☐ NF / I ☐ NF / S ☐ NF / TBI
☐ NF / AL ☐ NF / AFC

Signature and title	Date *(month, day, year)*